Medical Missionary

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Christ went about all the towns and villages curing every kind of disease and infirmity as a sign that the kingdom of God had come. So also the Church, through her children, is one with men of every condition, but especially with the poor and the afflicted. On their behalf she gladly spends herself. For she shares in their joys and sorrows, knows their longings and problems, suffers with them in the throes of death. To those in quest of peace, she wishes to answer in fraternal dialogue, bringing to them the peace and light of the Gospel.

Decree on the missionary activity of the Church, 12

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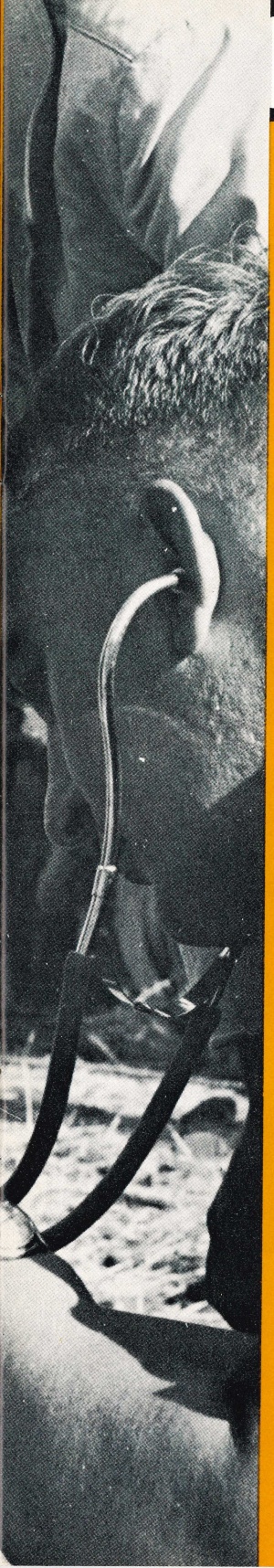

medical missionary

VOLUME 42 • NUMBER 5 • 1968

HEALTH

in developing nations

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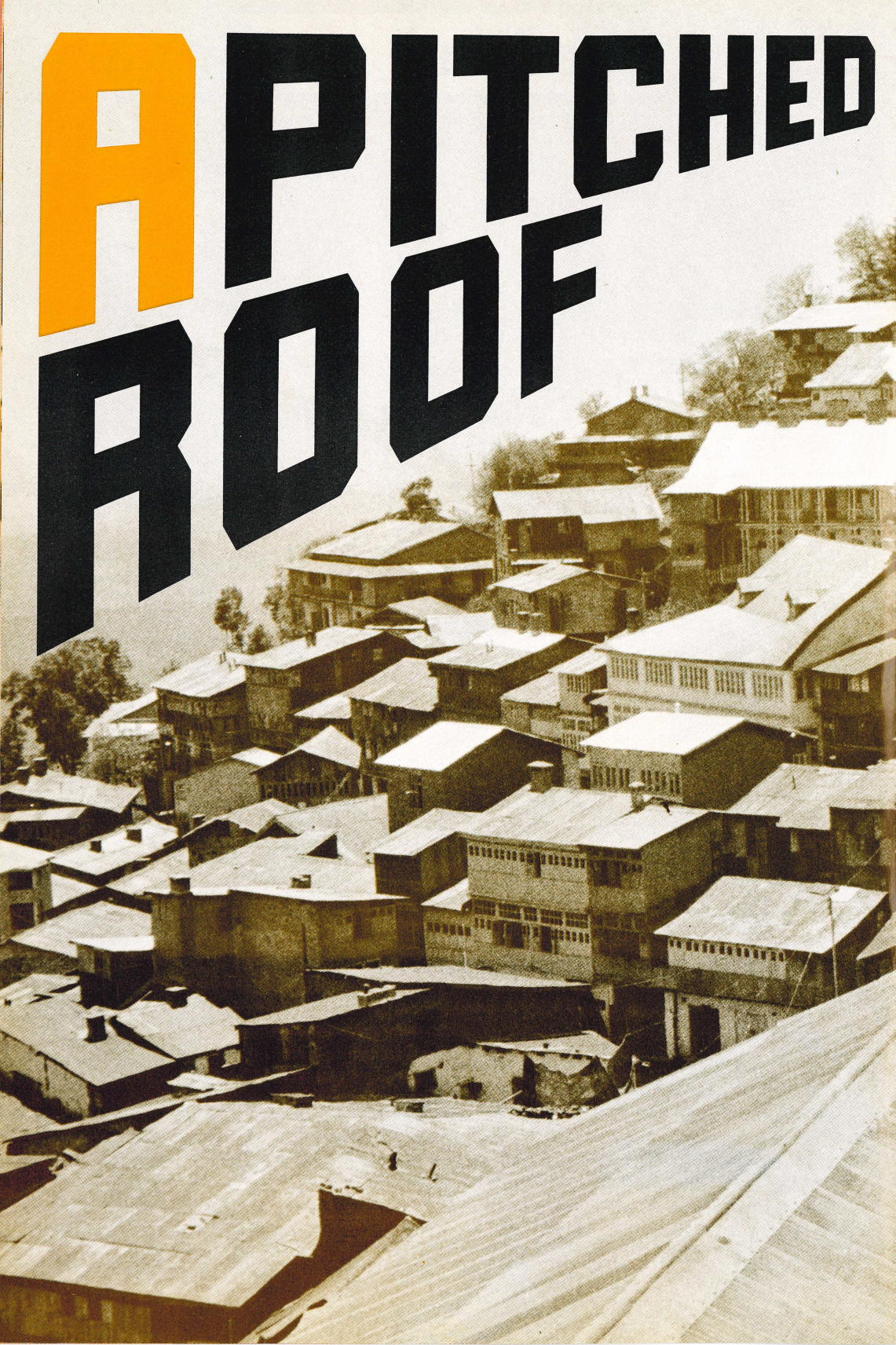
A PITCHED ROOF



One of the pleasures of living in some hot countries is that after the labor of the day one can retire to sleep under the stars on the flat roof of the house. Where snow is no problem, roofs can be flat and conducive to sweet repose or to quiet contemplation of the heavens.

A pitched roof is no place to take a nap. The pitch of an incline is determined by two things: the difference in height between one side and the other, and the distance between the two sides. Even when the difference remains the same, the pitch steepens if the two different heights are brought closer together.

What troubles the sleep of those who are concerned about health in developing countries are the ways in which gradients are getting steeper. There are sharper slopes between those who have and those who don't, between the possible and the actual, not only because of absolute differences but because Lazarus now lies at Dives' door and not far away over some impassable village track.

The Taj Mahal might never have been built if the omnipotence of Shah Jehan had commanded the simple powers of workaday modern medicine; his young wife would probably have survived him, and slept in a simpler tomb. But whereas unimaginable wealth and abject poverty then bowed to the same ills, the poor still die from illnesses from which today even a modest affluence can purchase rescue.

In an absolute sense a great many more people are probably cured or relieved, even in the poorest countries, than a century ago. What turns numb fatalism into sharp agony is the sharpness of the difference between what some can have and many cannot. The distinction is between need and demand. Much dedicated labor has probably succeeded, in some respects, in reducing need, but meanwhile demand has immensely burgeoned.

The factors which have steepened these gradients are familiar. One is transportation, which brings people and resources closer to each other, but also brings more people to the same, now overburdened, resources. Another is urbanization, which means that many people have moved from equilibrium at a low-level, rural standard of living into absolute as well as relative poverty in a more affluent urban milieu. A third is the absolute and terrifyingly rapid rise in population, nowhere near matched by increases in resources to meet their needs. A fourth is the explosion in technology, with the consequent gap between facilities which can utilize it and

those which cannot.

Fendall puts it this way:

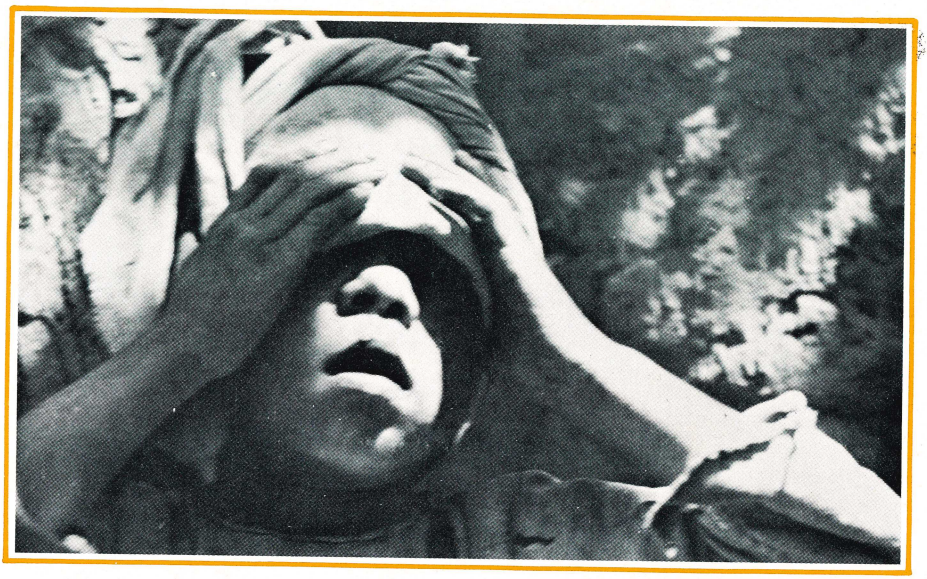
There are certain common factors which underline the state of all the underprivileged territories, though these factors may differ in degree and importance. These factors are: the limited economic resources, the paucity of the educational pool, the excessive demographic trends, the strongly conservative traditional cultures and the epidemiological disease patterns. The latter comprise the communicable diseases, the childhood and toddler diseases particularly marasmus, and kwashiorkor, as opposed to the predominance of the stress and degenerative diseases in the sophisticated societies. The social diseases and trauma occupy an important place in the disease pattern throughout all countries both privileged and underprivileged. I have referred previously to the fact that maldistribution is at least as important as the absolute shortages of professional personnel. In fact, perhaps it is more important.[1]

Dr. Spencer Snedecor, reporting on his medical survey visit to India,[2] writes, "In the short span of two decades . . . India has really achieved remarkable progress in health services; yet frustrating in the sense that the more they have accomplished, the greater the needs appear." Later he mentions a hospital with two doctors on duty, one caring for 150 inpatients and the other for 1,000 outpatients.

A century ago in that spot, two doctors capable of doing what was then known in medical science might have been well able to care for the numbers of people capable of getting there. No longer!

What is being done, what is happening in the presence of these changes?

One fact which is often taken for granted ought to be recognized as of immense significance: governments have at least in principle accepted



the responsibility of seeing to the health of populations. Practice may yet fall far short, but the principle is not even questioned in the developing world (*pace* the AMA!). Yet while accepting this responsibility, government is still tending to cope with health problems by means appropriate to the vanished era of gentler gradients.

First, despite a drastic change in doctor-population ratios, the doctor is assumed to be the indispensable person for treating any and all illnesses. If cornered, even a Minister of Health can be got to admit that an intelligent twelve-year-old child could be taught to diagnose and treat most of the illnesses that actually

constitute the major health problems of his people. Yet, lamentably, throughout the developing world the trend is toward abolishing the recognition formerly given to auxiliary health personnel. The presumed intent is that every sick person should have no less than the services of a full doctor and a full nurse; the effect is that millions for whom the doctor and the nurse are in fact out of reach will be denied even what could be given them.

In parentheses, this trend is working serious hardship on many church-related institutions. Not only was the training which they rendered at the nurse-auxiliary level a major contribution to the life and health of the country, but they themselves depended heavily on this cadre to staff their own services. They can afford neither to train nor even to employ the higher-level nurses which some governments are misguidedly insisting should be the only kind recognized.

If the governments in the developing world are misguided in this respect, it is the developed countries which must carry much of the blame, for it is we who have brain-washed ourselves as well as our neighbors into believing that the immense improvement in health in the West is attributable largely to the undoubtedly impressive improvement in medical education which stemmed from the epochal Flexner report of 50 years ago. Yet many other things

have changed in the US besides the medical school curriculum. The rise in the general level of public education, to mention but one factor, has surely been a major influence on health improvement.

Moved by national pride, governments are inclined to feel that professional standards unacceptable in the West are not good enough for them. Moreover, they are not uninfluenced by persons with a vested interest in acquiring academic credentials which will enable them to move abroad. It is therefore a matter of considerable importance that the medical profession in the United States is increasingly recognizing the need for and validity of a host of auxiliary cadres. This is a trend which should be publicized as well as applauded. If affluent America can learn to use auxiliaries of many varieties, it may be easier to persuade less fortunate countries to do so.

Dr. John Weir, medical director of the Rockefeller Foundation, puts it bluntly. After calling upon Western medical educators to design a simplified system of education to meet the actual needs of developing countries, he continues,

No doubt many will react to this suggestion with the statement that one must not regress to a physician who is not fully trained to the standard of the American Board of Medicine or that of the Royal College of Physicians. People who react in this fashion should recall to mind that in making such a godlike decision, they are in essence committing several million people to death - for lack of basic

medical attention.[3]

Second, and again following Western patterns, governments tend to assume that health care primarily means a hospital. As in the previous instance, the focus of attention is upon treating sick people. Has not this been the concern of the health professions, and their institutions, from time immemorial? Yet the result is the demoralization of the doctors and the deterioration of the hospitals under the hopeless burdens imposed by these assumptions carried over from a technologically simpler and less densely populated age.

Fendall[4] reports that underdeveloped countries spend not more than one-half to two percent of their gross national product on medical and health services (whereas even in the industrialized nations the proportion is 4-6% of GNP), and a per capita expenditure of between 50¢ and $10 (as opposed to $50-$200 in wealthier countries). Of these modest percentages, no more than 2% at most goes to public health measures which would prevent illness, as distinct from curative measures applied to illnesses which were not prevented. Obviously, no level of expenditure, in our present state of knowledge, could be expected to prevent all illness, but the tragic waste inherent in overburdened, impoverished hospitals and demoralized professional workers whose expensive education is inapplicable is but a footnote to the human waste of preventable illness in vast populations, many of whom get no treatment at all.

Full credit must be given to the fact that governments do accept prevention as well as treatment to be part of their responsibility. Indeed, much of what must be done is within the capability of no one else. It is a matter of proportion, of perspective, and especially of the potent element of prestige and recognition. A heart transplant unit is so much more glamorous than a whole province rid of parasites, or even of tuberculosis!

But who is going to pay for the heart transplant if the children are too undernourished to study and learn, if the laborer is too anemic to earn more than a pittance, if the taxpaying employer's profits are eroded by the wastefulness of ill-educated and disease-burdened workers?

The Westerner, leaning over the rail of his ship and watching the lethargic movements of the coolies, thinks smugly or pityingly of the oriental's lack of enterprise. How nimbly would he be hauling that bale if all his life his stomach had never been full, his hemoglobin never above 10 gm%? Can anyone really assess the influence on gross national product of the total amount of substandard health in the developing countries? And let's not forget to ask the same question of our own slums and ghettoes, too.

Meanwhile, if the posture of government is as sketched above, what is that of the churches, which still provide an impressive percentage of the medical facilities in many developing countries?

First, it must be acknowledged that governments would not be doing what they are today in health, as in education, had it not been for the pioneering leadership and example of the Church in earlier generations. Bishop Lesslie Newbigin writes:

I recently heard Principal Shoki Hwang of Taiwan giving a talk in Bangkok. He took as his starting point the promise to Abraham: "In thee shall all the families of the earth be blessed." (Gen. 12:3) Medical missions, he said, came to Taiwan as the fulfillment of that promise, but now the government of Taiwan has taken upon itself the business of healing. The medical mission in Taiwan has perhaps two hospitals. Now the government of Taiwan has perhaps fifty. Dr. Hwang insisted that we should interpret that as a fulfillment of the promise—the nations of the earth are blessing themselves, through the work of the Church. It is the coming of the medical missions which made that possible, but now this blessing of health is coming to

the people of Taiwan through the action of its government.[5]

But this being said, it must also be acknowledged that the churches, in their medical work as a whole (and with some brilliant exceptions), have tended to forfeit their leadership and accept their agenda from government—trying, where they can, to do it better, comforting themselves with the thought that they do it with greater compassion for the individual, but essentially doing the same thing: overburdening themselves to treat the sick, rather than moving into communities to keep them healthy.

Many of the people in developing countries have a much stronger sense of community than we individualists of the West. Yet our faith and scripture are rich in reminders that man in isolation is man crippled and incomplete. We have the archetypal experience of Israel as the people of a covenant. We have St. Paul's reminder that we are all members one of another. St. James tells us truly that faith without works is dead and to visit the orphan and the widow, but how far beyond the doing of good works is the invitation to love one another, to belong to one another!

Nor should we allow ourselves to be confused by the thought that these relationships apply only to the collectivity of those persons who accept the discipline and the confession of the visible church. They are a *sine qua non* and a consequence of the appearance of the church, which alone can bring them to their full fruition and incarnation, but they may exist, though imperfectly, without the church, and even be a means for the discovery of the church in the ripeness of time.

Yet our medical work tends to focus upon the sick person in isolation from his family and community —whom we regard as a nuisance during visiting hours. We put our main dependence on a highly complex (and alien) technology, mastered by a few and incomprehensible to the majority. Thus we tend to draw away the experiences of illness and of healing from the life and responsibility of the community into a separate enclave, dominated by us as Westerners or by us as professional experts. Might we not learn a great deal if we used what we know about community as Christians, not to speak of what can be taught us by psychologists and sociologists, to approach the sense of community which is the heritage of so many in Asia and Africa? We might then learn some things we never thought of before about making the village or the neighborhood itself our patient, and at the same time making it an essential part of our apparatus for treating the illness of the individual sufferer. In doing so we might discover again that healing is not only an act of compassion but a way of proclamation, carried out through our own fallible but faithful incarnation of the gospel.

1. Fendall, N.R.E.: "Auxiliary Personnel in Medical Education." Read at the Third World Conference on Medical Education, New Delhi, November 24, 1966.

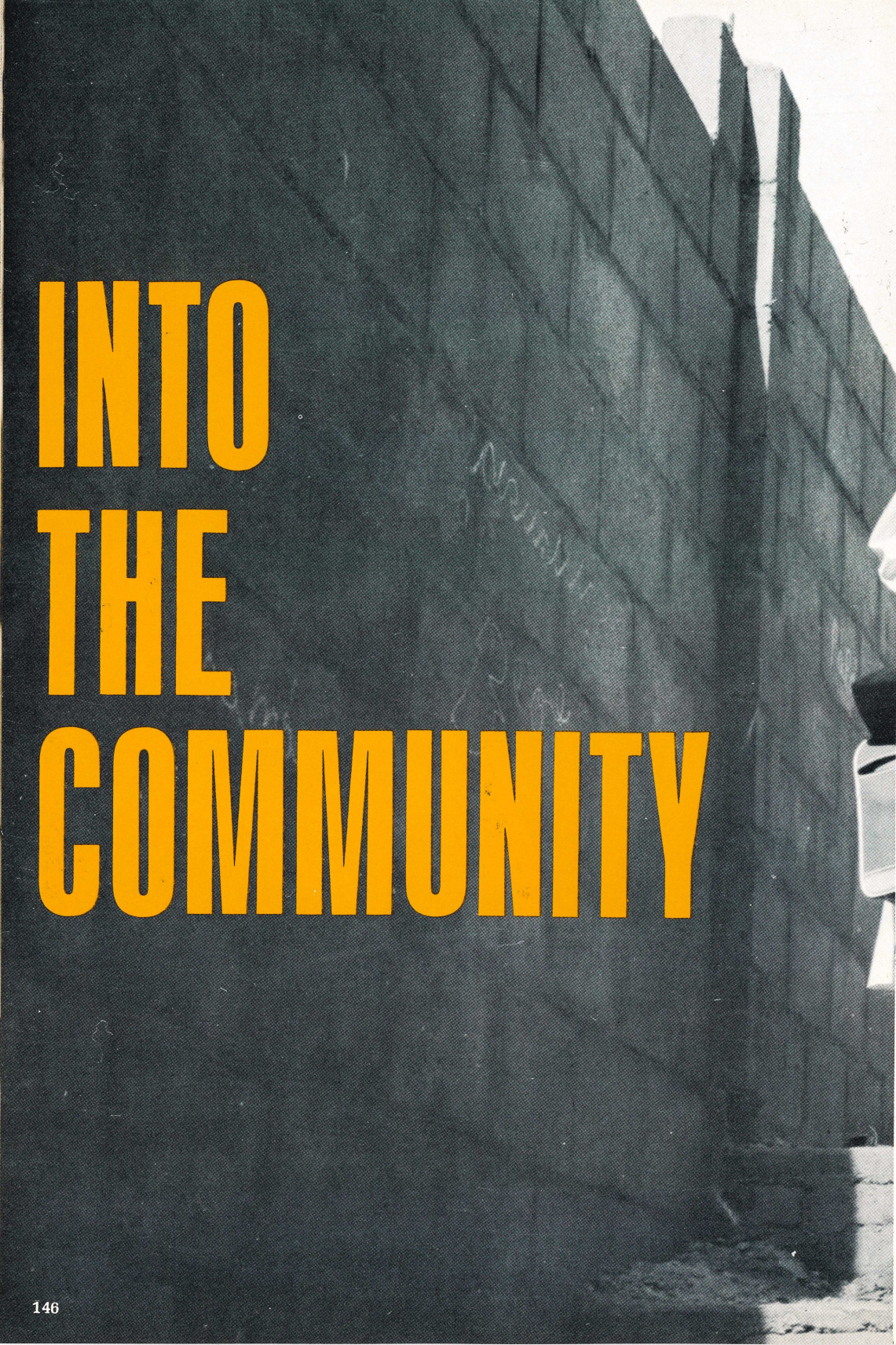
2. Snedecor, Spencer: "Regional Surveys of Church Hospitals in India; Summary of Impressions and Recommendations." January, 1968. Unpublished.

3. Weir, John: "Medical Care: Its Social and Organizational Aspects." New England Journal of Medicine 270:344-351, February 13, 1964.

4. Fendall: op. cit.

5. Newbigin, Lesslie: "The Healing Ministry in the Mission of the Church," in *The Healing Church,* World Council of Churches, Geneva and New York, 1965.

William L. Nute, M.D., is director of the Christian Medical Council, a unit of the National Council of Churches, Riverside Drive, New York. Doctor Nute has traveled extensively throughout southeast Asia and Africa, and has recently conducted a medical survey in India and Pakistan to benefit both Christian agencies committed to the ministry of healing and the people they serve.



INTO THE COMMUNITY

By Sister Jane Pellowski

"It is bad enough . . . that a man be ignorant . . . this cuts him off from the commerce of other men's minds. It is perhaps worse that a man be poor . . . this condemns him to a life of stint and scheming, in which there is no time for dreams, and no respite from weariness, but what surely is worse, is that a man is unwell, for this prevents his doing anything about his poverty or ignorance." (George Kimble)

Emptiness, despair, famine, oppression, disease: each contributes its ugly share toward the poor health of nations. And if there ever was a time when decisive and creative attempts to erase the scars they produce are desperately needed, that time is now.

We are like straddlers of two worlds, afraid to plunge into the one ahead, and unwilling to look back on the one from which we have emerged. And yet the responsibility is ours; it is in us that the process of life is carried to fulfillment. Our call is to be the needed link, the bridge, the promise of a better future.

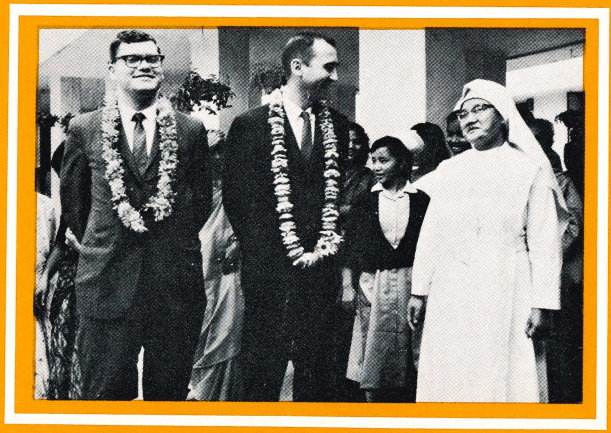
What faith we must have in our own powers! How are whole peoples delivered from ill health to a state of well being? What refocusing, re-directing, re-newing, redeveloping, re-planning will provide the needed answers to the Biafras, the famine plagued Indias, the Latin Americas?

In the face of issues that are so universal, the temptation is to speak and act in general and universal terms. However, the precise action which this person, this family, this group, this nation will pursue, is what in the end will determine progress. History will judge us accordingly.

Recent trends in the area of health services reflect a deep desire and concern toward developing varied approaches to individualized and personalized health care. Efforts to bring needed services *to the people* are sprouting everywhere. Significantly, this development does not reduce the prestige, the work or the need for the large centralized health facility, it rather enhances it. The neighborhood service centers, the health education efforts, the mobile clinics, the school programs, all serve to broaden the entire base of health services within a given community.

These concerted efforts toward preventive medicine must receive even greater emphasis in the future. Basic health education, sanitation, nutrition and a host of other medical and para-medical disciplines must be brought *into the community* at a personal level and in a comprehensive and acceptable form. The presentation of better health standards to a group must bear some relationship to the day to day life and death of that same group, otherwise it is not received in a way which produces change.

NEW VISION

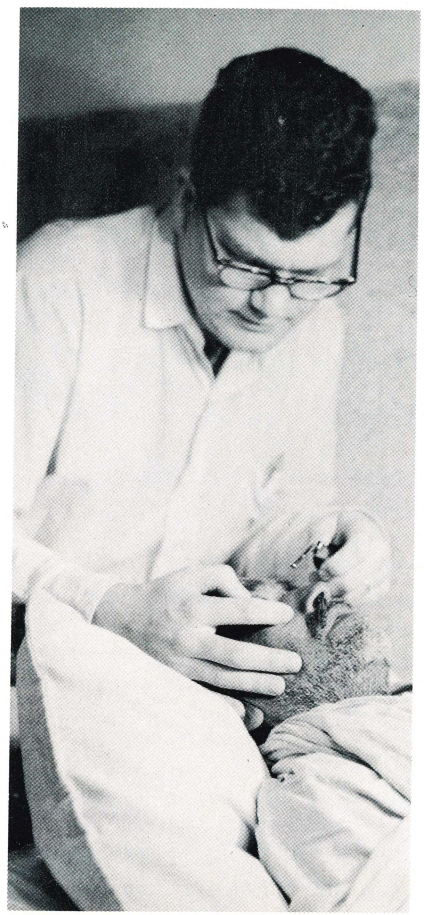


William C. Caccamise, M.D., an ophthalmologist from Rochester, New York, first went to Holy Family Hospital, Patna, India, in September, 1951. In January, 1968, he returned for the fifth time since 1959, when he determined to conduct a two-month eye clinic in Patna every two years. Besides donating his own services, the doctor brings equipment, medicines, and a medical resident with him.

This work of Dr. Caccamise has been a genuine, continuing investment in the health of India. To see 135 patients in the morning and perform 15 operations in the afternoon six days a week indicates, if only numerically, the impact that the eye clinic has made. Its purpose has been to alleviate the acute immediate need for eye care in rural India. Though the country now has skilled ophthalmologists, they reside in the metropolitan areas, leaving 80% of the population unattended in the villages with the dusty climate, poor sanitation and deficient diet that exist there.

Concomitant with this relief of immediate need has been a change of attitude in the people toward eye disease and its treatment. They have learned to seek help when their sight is first impaired rather than after permanent damage has been done. They now view cataract and glaucoma surgery as definite attempts toward restoring their vision. Indirectly, the eye clinic was responsible for changing the state law in Bihar concerning the legality of donating eyes. The success of the corneal transplants done by Dr. Caccamise is recognized as a confirmation of rather than an attack against the great Hindu respect for living things.

If a patient can be helped at the clinic, he is helped. Otherwise, he

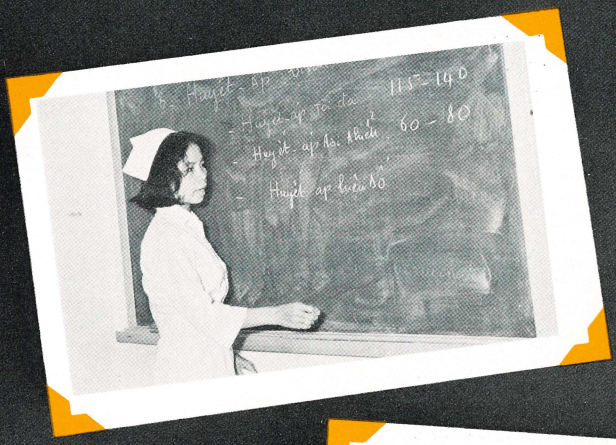


is told the truth about his condition. If the clinic is a person's last chance between sight and blindness, there is no limit to the care he will receive. The reputation of the clinic has been built by word of mouth. "A man goes home from the clinic seeing and the word gets around. That word of the market place is important," the doctor explained.

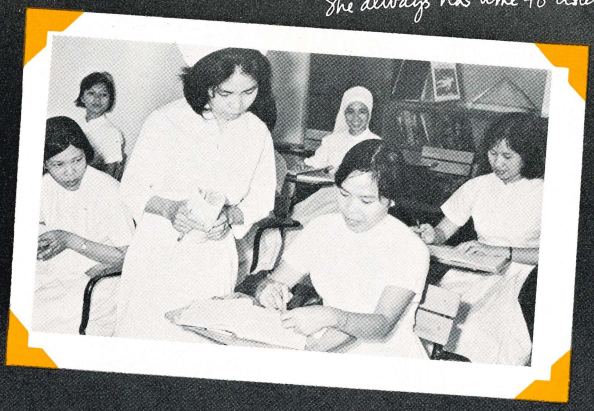
The eye clinic has also made a definite contribution to the field of medical education. Many Indian ophthalmologists are invited to the clinic to observe surgical techniques. During recent years, Dr. Caccamise has brought a medical resident with him to assist him in the out-patient department and in surgery. Financed by a special fund of the University of Rochester Medical School, the resident gains invaluable medical and non-medical experience not available in the United States.

Dr. Caccamise admits that it is difficult to pull up roots and go to India for two months every other year. He has no partner, so his practice stops completely. It is still more difficult, however, to leave behind his wife and five children. "I can resume my practice quite easily on my return. But if something should happen to one of the children while I'm away . . ." Then he adds, "But my wife understands my purpose in India. And Patna is like home."

A Dream



Mrs. Huynh thi Cuu is a patient instructor. She always has time to listen.

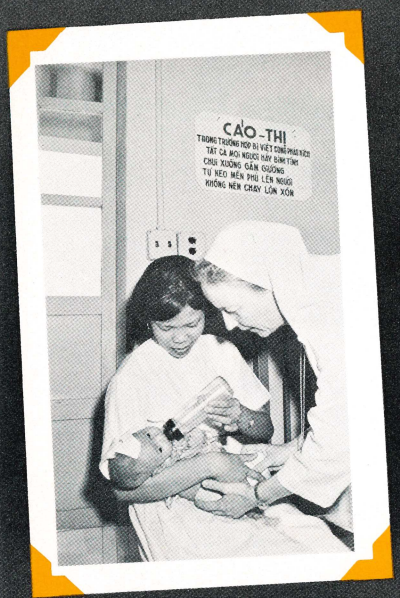


By Sister Rosalie Pollinzi

Phuoc Loc Tho means happiness, prosperity and longevity. It accompanies every Vietnamese hello and good-by. It has been portrayed by the figures of three little men, wizened with years and full of wisdom. The greeting brings to mind a fourth word: *Suc Khoe* or "health." The happiness, prosperity and longevity of a man or a people depends in large part upon their health.

Suc Khoe is not an easy thing to assure in a country such as Vietnam. It has been difficult to meet the overwhelming medical needs resulting from 20 years of war. To say that hospitals are overcrowded and understaffed or that the nurses in particular have found the demands beyond their strength is to understate the situation with worn-out

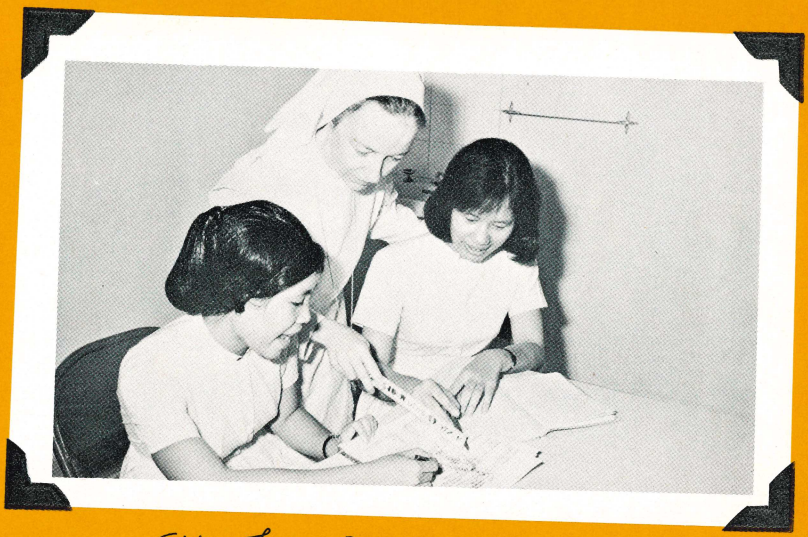
Even making beds can be fun --- sometimes.


CẢO-THI
TRONG TRƯỜNG HỢP BỊ VIỆT CỘNG PHỤC KÍCH
TẤT CẢ MỌI NGƯỜI HÃY NẰM YÊN
CHUI XUỐNG GẦM GIƯỜNG
TỦ HOẶC NẾN PHỦ LÊN NGƯỜI
KHÔNG NÊN CHẠY LỘN XỘN

It's exciting to feed a baby or make ward rounds for the first time.

phrases. Holy Family Hospital, Quinhon, has experienced for over seven years the unbelievable challenge behind such inadequate words. In April, 1968, the hospital set a new milestone in its existence when it opened the first Assistant Nurse's Program in the province of Binh Dinh.

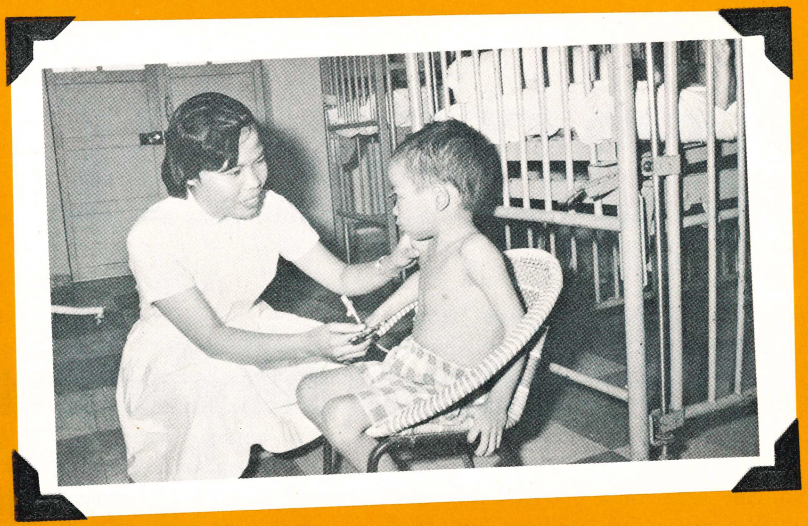
The school marked the completion of a building project to connect the two original parallel wings of the hospital. It climaxed months of paper work and many trips to Saigon to confer with the Vietnamese Ministry of Health and the USAID. The school progressed despite the constant and damaging activity of the Viet Cong during the early part of the year. At the formal opening ceremony on April 15th, the Vietnamese provincial and mili-



Sister Therese Dion lends a helping hand

tary officials of Binh Dinh presided, together with Dominic Hoang van Doan, the Bishop of Quinhon. Many Vietnamese, Koreans and Americans who had assisted the project in immeasurable ways also attended.

Sister Therese Dion, the Directress of the school, and Mrs. Huynh thi Cuu, a Vietnamese nurse from the Ministry of Health, are the main instructors in the school. Several Vietnamese doctors in the military and in private practice in Quinhon have generously offered their services in instructing the students. The pharmacist from the Vietnamese military hospital also instructs the students in a basic knowledge of pharmacology. The entire program is conducted in the Vietnamese language. Graduates will receive government recognition. Surprisingly, in a



It's not so bad little man. I'll help you.

Lt. Nguten anh Dung teaches pharmacology.

country so desperately in need of adequate nursing personnel, there are at present only two three-year nursing programs in the country and several one and two-year programs.

Thirteen students are now being trained at the school. All have had at least seven years of education and have received a diploma for satisfactory completion of this basic requirement. Four of the students are Vietnamese Sisters. The women are eager to learn and they possess within them great potential for serving their people.

Phuoc Loc Tho—this is the greeting. Three old men who have been healthy enough to have lived a long time — they are the symbol. *Suc Khoe*—may the greeting come true. The new nursing program at Holy Family Hospital, Quinhon, is a step in that direction.

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A KINGDOM

By Sister Kristine Malins

The Kingdom of God has arrived. Change your hearts. Don't be afraid. Your Father plans to give you the Kingdom. Sell your possessions and give the money away. Set your heart on the Father's Kingdom and your food and drink will come as a matter of course. Pray always, like this, "May your Kingdom come."

A Kingdom? What on earth are you talking about? The development of governmental systems has definitely taken a turn away from individual kings and their semi-divine authority over their subjects to the "rule of the people" who are slowly though somewhat erratically making one gigantic representative assembly of the whole planet. Where in this world is the Kingdom *now*?

The Kingdom of God never comes by watching for it. Men cannot say "Look, here it is," or "There it is," for the Kingdom of God is inside of you.

Inside me?

The Kingdom is like a treasure hidden in a field, a pearl purchased at great expense. A tiny seed carries within it all the potential of a tree. A little yeast mixed with a lump of dough leavens the whole mass. Do you understand these things?

I think so. The Kingdom, rooted in the human heart, is a hidden ultimate value that transforms the life and the world of a man. Goodness must be a far deeper thing than fidelity to ritual and discipline.

Indeed! Happy are the humble-minded, those who know what sorrow means, those who claim nothing, those who hunger and thirst for goodness, the merciful, the utterly sincere, the peacemakers, and the persecuted. The Kingdom of heaven is theirs. Anyone who does not accept the Kingdom of God like a little child will never get into it at all.

Then this seed within me must be accepted, like a wedding invitation. I am always free to say I cannot come or when I finally show up, refuse to wear the appropriate dress.

Believe me, a man cannot even see the Kingdom of God without being born again — through water and the Spirit. Even then, some men let the devil come and take away what was given to them. Others receive their gift without hesitation, accepting it joyfully, but because they have no real depth, they lose their faith in hard times. Still more men let the worries of the world and false ambitions choke the Kingdom within them. But those who accept it, like good soil, produce a crop in proportion to what has been given them. You must do your utmost to get in through the narrow door, for many will try to do so and will not succeed.

But the Kingdom is such a risk. You ask me to give up all I have in exchange for a cross. Who relishes that? Hang my hopes on a mustard seed? Even with the best intentions, I get distracted with my own comfort or frightened by the downright paradox of life "in the Kingdom." I guess I play the rich young

man often. He had made such a good start, but ended up so sad because he had too many attachments. Maybe I should imitate that leper you met once. "If you want to, Lord, you can make me clean."

Of course I want to. Be clean! I came not to call the righteous but the sinners. And I will tell you the secret of his hidden Kingdom. It sweeps over the earth like the seed that a man scattered in the ground. He went to bed each night and got up every morning and the seed sprouted up and grew though the man had no idea how it happened.

Whether I like it or not, the Kingdom is. The Father planted it within the hearts of men by calling them to be his people. One man — you, Jesus — brought forth a crop one hundred percent. That did it for the rest of us. Now, it is only a matter of time. No weakness, lack of understanding, no sin can stop it. And yet, I, for one, cannot let this Kingdom sweep over me unawares. Zaccheus climbed up a sycamore tree and came down a redeemed man with a guest for dinner. The paralytic picked up his pallet at your word and walked. I do not want to do less.

Those who love me, follow my teaching. When the Son of Man comes in splendor, he will take his seat on a throne to judge the nations. If you have broken your bread with the hungry, shared your home and clothing with the needy, cared for the sick and imprisoned — no matter how wretched they were— I shall reckon that as the acceptance and proclamation of the Kingdom. Its inheritance will be yours forever.

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COVER PHOTO:
Peshawar, West Pakistan.

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There is a great harvest but only a few are working in it. Pray to the Lord of the harvest that he will send out more reapers. (Luke 10:1)